Resp Provider: _____

Patient Balance:
Active Payment Plan:
Would you like us to save your CC for future payments? Y / N

Name: _____

Preferred Name: _____

Date of Birth: _____

Social Security Number: _____

Sex: ( )Male ( )Female

***Sexual Orientation:** _____

***Gender Identity:** _____

***Primary Language:** _____

***Ethnicity:** ( )Hispanic or Latino ( )Not Hispanic or Latino

***Race:** ( )American Indian or Alaska Native
( )Asian ( )Black or African American
( )Native Hawaiian or Other Pacific Islander ( )White

Marital Status: ( )Married ( )Single ( )Divorced

Mailing Address: _____

City,State,Zip: _____

Do you currently have a Physical Address? ( )Yes ( )No
Homless ( )

Physical Address: _____

City,State,Zip: _____

Phone (1): _____ ( )Cell ( )Home ( )Work

Phone (2): _____ ( )Cell ( )Home ( )Work

***Family Size:** _____

***Education Level:** Haven't Graduated ( ) High School ( ) GED ( )
College Degree ( ) Other ( )

***Employment:** ( )Employed ( )Retired ( )Unemployed ( )Other

Employer: _____

Occupation: _____

Phone: _____

***Yearly Family Income:** _____

***Veteran Status:** **Veteran ( )** **Non-Veteran ( )**

EMERGENCY and/or PARENT/GUARDIAN CONTACTS (if under 18)

Name: _____

Relation: _____

Phone: _____

Name: _____

Relation: _____

Phone: _____

PRIMARY INSURANCE

Insured Name: _____

Relationship to Patient: _____

Insured Phone: _____

Insured Date of Birth: _____

Insured Social Security Number: _____

Insurance Company: _____

Insured ID: _____

Policy Group: _____

SECONDARY INSURANCE

Insured Name: _____

Relationship to Patient: _____

Insured Phone: _____

Insured Date of Birth: _____

Insured Social Security Number: _____

Insurance Company: _____

PREFERRED PHARMACY

Name: _____

I am interested in learning about Three Bears ( ) or Geneva Woods ( ) pharmacy deliveries.

PATIENT PORTAL & ELECTRONIC COMMUNICATION

I am interested in Electronic Communication: ( )Yes ( )No
I would like to:

( ) Opt-In with Portal Access: I **do** want access to my portal account online and I **do** want electronic communications.

( ) Portal Access Only: I **do** want access to my portal account online, but I **do not** want electronic communications. Sunshine will send one email to enable your portal account- you disable all other electronic communications within your account.

( ) Opt-In for text only (*email address still required)*

Email (*required to Opt-In*): _____
Portal Status:

I have read and received the following:

- Please read Privacy Practices - See clipboard -

( ) SCHC Patients' Rights and Responsibilities
( ) Patient Financial Responsibility & Responsibilities
( ) Notice of Privacy Practices Acknowledgement (HIPAA)

I request Sunshine Community Health Center (SCHC) to provide me and/or my family member with medical/behavioral/dental care. I acknowledge that it is my responsibility to pay for care according to the fees established, whether or not these fees are paid by insurance. I authorize the release of my protected health information necessary to process insurance claims. I assign directly to SCHC all insurance benefits, if any, otherwise payable to me for services rendered. If my provider prescribes controlled substances, I give SCHC permission to gather information regarding controlled substances prescriptions, past and present, from other providers and pharmacies

Patient /Guardian: _____ **Date:** _____

***Informaton required is a measurement for SCHC funding**

Yellow highlighted areas must be filled in